

The Role of Medical Diplomacy in Stabilizing Afghanistan

by Donald F. Thompson

Overview

Comprehensive stabilization and reconstruction of Afghanistan are not possible given the current fragmentation of responsibilities, narrow lines of authorities, and archaic funding mechanisms. Afghans are supportive of U.S. and international efforts, and there are occasional signs of progress, but the insurgent threat grows as U.S. military and civilian agencies and the international community struggle to bring stability to this volatile region. Integrated security, stabilization, and reconstruction activities must be implemented quickly and efficiently if failure is to be averted. Much more than a course correction is needed to provide tangible benefits to the population, develop effective leadership capacity in the government, and invest wisely in reconstruction that leads to sustainable economic growth. A proactive, comprehensive reconstruction and stabilization plan for Afghanistan is crucial to counter the regional terrorist insurgency, much as the Marshall Plan was necessary to combat the communist threat from the Soviet Union.¹ This paper examines the health sector as a microcosm of the larger problems facing the United States and its allies in efforts to stabilize Afghanistan.

A detailed RAND Corporation study cites the absence of an overarching, nationally driven plan, poor coordination, and the lack of a lead actor as major barriers to successful health sector reconstruction and stabilization.² Three obstacles identified in the RAND study are at the root of our failing efforts in Afghanistan: poor planning and coordination within and between U.S. Government military and civilian agencies; lack of an overall health sector reconstruction game plan and the resources required for implementation; and misunderstanding of and failure to adjust for the complex counterinsurgency challenges of security, stabilization, and reconstruction. Focusing on health provides opportunities to overcome Taliban influence, strengthen the young Afghan government, and set the conditions for long-term economic growth. The lessons and principles from Afghanistan have broad regional

and global application and should be adapted as part of our enduring national security strategy.

Medical interventions are an important component of a diplomatic strategy to regain moral authority for U.S. actions, regain the trust of moderate Muslims, and deny terrorists and religious extremists unencumbered access to safe harbor in ungoverned spaces. Such efforts in Afghanistan will be intensely interagency driven and must be tightly integrated and closely coordinated with offensive military operations, defensive security actions, and other reconstruction activities so that military actions are supported and resulting advantages are solidified. Our security architecture must integrate these medical activities into an appropriately time-phased campaign across the spectrum of conflict.

Nationbuilding in Afghanistan will be more difficult and time-consuming than it was in post-World War II Europe. Afghanistan has a long history of tribal allegiance rather than nationalist loyalty, and it has endured an almost total destruction of its infrastructure, a process that began with the Soviet invasion almost 30 years ago. The threat to Afghanistan from diffuse insurgent networks is much more difficult to localize than was the threat of communism in Europe. Walling off terrorists is not possible in Afghanistan, where high value is placed on the free movement of people and goods across and within national boundaries. Furthermore, as our national strategy for stabilization and reconstruction is reappraised, senior leaders must carefully consider how to integrate effectively all elements of national power and create the appropriate policy framework—coordinated interagency strategy, doctrine, authorities, and resources—in which each instrument may be applied.

Strategic Goals

An effective counterinsurgency campaign against the Taliban requires a combination of offensive, defensive, and stability operations, where stability operations include civil security, civil control, essential

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services, good governance, economic development, and infrastructure development.³ Essential services include water, electricity, health care, and education—all of which support economic growth and progress toward self-sufficiency. These services are unavailable to most Afghans, adding to discontent and societal tension and fueling the insurgency. Providing access to these services is the crucial counter-insurgency step that goes hand in hand with security. Strategic civil-military partnerships must be developed that create unity of effort where offensive military operations, defensive security operations, and the correct aspects of stabilization are applied across the spectrum from conflict to peace.⁴

Increasing the effectiveness of Afghan government institutions and redressing popular grievances regarding essential services and corruption should shift the support of the population from the Taliban insurgency to the government of President Hamid Karzai. Improvements in the health sector are especially important. U.S. military forces are quite successful with conventional combat operations, but they struggle with engagement of crucial civilian components of the government of Afghanistan. While more resources are necessary, they will be wasted if not applied more effectively.

Available Tools Unused

North Atlantic Treaty Organization (NATO) Provincial Reconstruction Teams (PRTs), originally conceived as the model for reconstruction and stabilization in postconflict settings,⁵ have been criticized for their concentration on short-term, unsustainable construction projects that crowd out local initiatives and fail to stem the rising violence in Afghanistan.⁶ NATO and the international community have been faulted for the lack of a well-crafted, publicly articulated comprehensive master plan for reconstruction that applies lessons learned to enhance economic development.⁷ These problems stem from American inexperience with small counterinsurgency wars; the attempt to reap a peace dividend from the end of the Cold War by reducing defense budgets; and the focus on efficiency, technology, and specialization in many of our domestic and national security agencies. The Department of Defense (DOD) must now rapidly realign civil-military authorities and resources for counterinsurgency and stability operations.

Poor resource support and central coordination for local efforts are hampering the local and regional counterinsurgency impact of the PRT in the restive Kunar Province bordering Pakistan. As an example, the

Taliban have maimed Afghans who work at the PRT compound, cutting off noses and ears to send a threatening message to others. When the PRT commander sought assistance for reconstructive surgery to counter the insurgents, a specialty hospital in Kabul operated by the CURE

International nongovernmental organization (NGO) designed a plastic surgery training program that would train 2 Afghan surgeons a year while providing reconstructive surgery to 30 patients each year. The \$430,000 project cost of building sustainable capacity within the Afghan system was denied by the U.S. Central Command Humanitarian Assistance coordinator. Funding this initiative would have been a relatively in-

expensive way to show U.S. support for local populations, would have helped to boost local morale, and would have built needed, sustainable capacity in the Afghan health sector.

U.S. military forces are explicitly trained, equipped, and organized for short, decisive wars against massed enemy forces. However, they come up woefully short when the enemy instead seeks to discredit the development of a competent government and demoralize and terrorize civilians while using them for cover. Civilian U.S. Government departments and agencies have shifted their focus from operational capacity to policy setting and are generally hampered by lack of specific congressional authorization to operate internationally and to obligate their funds outside their domestic domain. The complexity of the Federal Acquisition Regulations and the risk-averse nature of contracting officers often result in missed opportunities to act quickly in restoring essential services.⁸ Civilian personnel rules generally are not designed to support deployment of U.S. civil servants when it comes to matters of compensation, life insurance, medical evacuation, and long-term rehabilitation. Many capabilities within the military, civilian agencies, and NGOs have become so specialized as they seek increased efficiency that they have lost their ability to adapt and respond to a changing reconstruction and stabilization environment.

In one case, over 18 months of negotiation were required to assign two technical experts from the U.S. Public Health Service Commissioned Corps, part of the Department of Health and Human Services (DHHS), to the office of the Combined Security Transition Command—Afghanistan (CSTC—A) Command Surgeon to help with civil-military health sector development. These Commissioned Corps officers have outstanding expertise in maternal and child care, development of basic health services across cultural barriers, communicable disease control, and food and drug safety, and they work widely throughout U.S. Federal medicine in the Indian Health Services, Centers for Disease Control and Prevention, Food and Drug Administration, and other Federal departments and agencies. DOD ultimately was required to fund not only travel, deployment, and hazardous duty pay, but also baseline salary, benefits, retirement, medical evacuation, and even death benefits because DHHS is not funded for international stabilization and reconstruction work. Twenty Commissioned Corps officers volunteered for the two CSTC—A positions that were created; these experts could be more widely used if DHHS were resourced for these international developmental tasks.

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Dr. Donald F. Thompson is Special Assistant for Biological Defense in the Office of the Secretary of Defense for Policy. He is a Colonel and a Senior Flight Surgeon in the U.S. Air Force and specializes in Family Medicine and Preventive Medicine. Dr. Thompson was Command Surgeon for Combined Forces Command—Afghanistan and Combined Security Transition Command—Afghanistan from March 2006 to April 2007.

Who Is Responsible for What?

Efforts to rehabilitate the health sector in Afghanistan suffer from many of the interagency coordination defects that have plagued the United States in its broader approach to postconflict stabilization efforts. The Federal Government is largely organized such that one department is in the lead in preconflict, conflict, or postconflict settings, while the others assume secondary importance. In theory, at least, the State Department handles preconflict negotiations; DOD handles the conflict and rapidly exits when the conflict ends; and someone other than DOD handles all the postconflict work. This scheme fails in a counterinsurgency because it does not provide for successful postconflict reconstruction, nor does it account for dealing with nonstate actors, terrorists, or insurgents. Insurgents blend in with and terrorize the population, undermine the government, and seek to perpetuate discontent, disorder, and instability. The key step in a counterinsurgency is to separate these insurgents from the support of the population. Mao Tse-tung described insurgents as fish swimming in the water of the population. Counterinsurgency is much more than simply attacking the fish, though sometimes this is the right approach. The goal is to separate the fish from the water by providing economic and political changes that undercut popular support for the insurgents.⁹ Insurgents have provided medical services to win over the rural population; Taliban-owned hospitals operate in Pakistan along the Afghanistan-Pakistan border and provide medical services to Afghans in the region. Focused health sector development within Afghanistan will draw the support of the population from the Taliban insurgents to the Afghan government.

Counterinsurgency stability operations may require offensive military actions at one time, while at another time security may be provided merely by the threat of military action, by covert military action, or by host-nation army or police forces. Essential services of clean water, emergency food, or basic health care may be provided by military personnel in a highly unstable setting or while active conflict is taking place but should be provided by NGOs, international organizations, or the host-nation government as soon as conditions permit. Developing government capacity to provide health care services or confirming the quality of existing government services may initially be achieved by military-run PRTs but should quickly transition to U.S. civilian agencies assisting the host-nation governmental authorities. The common theme is that as the counterinsurgency operation evolves and stability and security increase, the host-nation government becomes stronger and takes over actions. Implementers of each specific task may change, but all offensive military operations, defensive security operations, and reconstruction and government capacity-building activities must be tightly integrated by all military and civilian participants across all phases of conflict.

Required unity of effort has not been achieved even within the U.S. military in Afghanistan today—one command structure controls offensive counterterrorist actions, and another one handles defensive security actions, security sector reform actions, and reconstruction actions. When the need for other sources of technical expertise from civilian agencies and other sources is considered, it is clear that the current organizational structure is inadequate.

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New DOD policy elevates stability operations to a core competency akin to combat operations and states that while actions may best be performed by indigenous, foreign, or U.S. civilian personnel, U.S. military forces shall be prepared to perform all tasks necessary to maintain order when civilians cannot do so.¹⁰ The Government Accountability Office notes that DOD lacks interagency coordination mechanisms for planning

and information-sharing and has not identified the full range of capabilities needed for stability operations or the measures of effectiveness essential to evaluate progress. Performance measures must consider the crucial societal elements of civil security, civil control, essential services, governance, economic develop-

ment, and infrastructure development, and are doubly important when taking on a new mission—stabilization and reconstruction—in a new environment—postconflict—against a new enemy—an extremist insurgency.

Opportunities Lost, Lessons Not Learned

Nowhere is this disorganization more apparent, nor have more opportunities been lost, than in the areas of health and medical care in Afghanistan. Too much effort is wasted on poorly coordinated Medical Civic Action Programs (MEDCAPs), where U.S. and NATO International Security Assistance Force (ISAF) military medical personnel deliver health care directly to Afghan civilians, undercutting the confidence of the local population in their own government's ability to provide essential services.¹¹ While reasonable people may disagree about the effectiveness of MEDCAPs in nations where there is no functioning government to provide this health care, MEDCAPs in Afghanistan are largely inappropriate because they fail to contribute to long-term capacity-building. These teams are more appropriately used as tactical implementers of reconstruction projects in conjunction with PRTs, as described below.

Other activities have mixed results. Training of skilled birth attendants and midwives has turned out many graduates, but their poor distribution around the country has left many areas underserved, so the record-high maternal mortality rate remains extreme in most rural areas. Much effort is wasted when medical and educational infrastructure is built without assuring that trained Afghan personnel are available to operate and sustain the facility. Such criticism has been leveled at PRTs at the provincial and local level, at DOD in development of the Afghan National Army (ANA) and Afghan National Police (ANP) health care systems, and at DHHS at the level of the Ministry of Public Health.¹²

U.S. civilian government efforts have not focused on comprehensive reconstruction of the civilian and military health sectors but rather have largely been limited to U.S. Agency for International Development (USAID) attempts to provide for NGO-delivered primary health care services under the Ministry of Public Health's Basic Package of Health Services (BPHS). USAID, the European Community, and the World Bank are the primary donors supporting development of the BPHS, and have demonstrated considerable success in making this basic level of health care available to 82 percent of the population (defined as the percentage of the entire population within a 2-hour walk of a village health post or

better medical facility). Medical care is adequate, though minimal, for most Afghans. The rest of the health sector remains largely untouched.

Obstacles to Success

Resource restrictions reinforce and perpetuate poor performance and lost opportunities. Authorities for spending U.S. taxpayer funds are outdated, having been designed for small-scale humanitarian assistance in emergency settings where an effective government response is lacking. DOD Overseas Humanitarian, Disaster, and Civic Aid (OHDACA) funding is restricted to humanitarian emergency assistance that benefits only civilians and may not be used to build sustainable capacity. Bureaucratic obstacles to getting Afghan projects approved made OHDACA essentially a useless funding mechanism. Congress created the Commander's Emergency Response Program to provide some flexibility to the local commander for urgent humanitarian projects, but these funds are unavailable for developing substantive capacity in the civilian health care system. Other experts have recognized the deficiencies of such humanitarian assistance programs and are attempting to develop measures of effectiveness that will improve transparency, cost effectiveness, and interagency collaboration.¹³

Security Sector Health Care: Independent or Integrated?

DOD has invested hundreds of millions of dollars in the ANA health care system yet is unable to apply funds where needed to make the system sustainable. Also in desperate need of rebuilding are the civilian institutions that provide direct support to the Afghan National Security Forces (ANSF), such as civilian medical and nursing schools, civilian allied health professional training institutes, emergency medical services systems, and clinical care for family members of the ANA and ANP.

In many nations, entitlement to use the superior military health care system is extended to political dignitaries and dependents of military personnel, leading to a multitiered system and discontent from the masses destined to use the underfunded, underequipped, second-class civilian system.¹⁴ The United States is developing such a disparate system in Afghanistan by putting almost all of its health sector reconstruction resources into the security sector while ignoring the civilian sector. Current resource restrictions stall the development of a sustainable health care system with the correct central structure and relationship within and between ministries.

Afghan National Security Forces funds could be used to build an expensive military medical school for the ANA (despite a lack of professors to provide a quality medical education), but could not be legally used in the existing civilian medical university. Less than 5 percent of the amount required to build a military medical school could build tremendous capacity and quality in the civilian medical university to provide a sustainable source for all the physicians needed for the army and improved quality within the civilian health care sector. Despite strong

efforts to integrate health care services for the ANA and ANP into an efficient, cost-effective, sustainable ANSF system, cultural antipathies between the army and police are leading toward separate combat medic training for the two systems and redundant hospitals in Kabul, despite hundreds of empty hospital beds in the ANA hospital already renovated with U.S. dollars.

U.S. and ISAF military medical resources are primarily used to deliver health care to Afghan security forces and Afghan civilians, not

to treat U.S. and coalition casualties. On any given day, 70 to 90 percent of patients hospitalized in coalition medical facilities are Afghans. Almost all Afghan casualty movement must be by U.S. and ISAF aircraft, since civilian ambulances are almost nonexistent. These dramatic inequities were demonstrated by a heroic medical evacuation mission that attempted to save four

Afghans critically burned in two separate mass casualty incidents. A U.S. Air Force C-17 aircraft with two 3-member Critical Care Air Transport Teams was launched from Al Udeid Air Base in Qatar and landed in Kandahar to retrieve two Afghans who were being maintained on ventilators from ISAF facilities. From there it flew to Tarin Kowt in Uruzghan Province for two more Afghans on ventilators in the ISAF facility there, and then it went to Kabul to transfer the patients to the Afghan system, where ventilators are almost unknown. The patients were transferred from the most modern of Western medicine—flying intensive care units—to Afghan ambulances where each patient had to be manually ventilated. Three of the four patients died of their burns within 24 hours; the fourth was transferred to the U.S. facility at Bagram Air Base, where he died the next day. Some may question the valiant extent to which ISAF went in attempting to save these four civilians, but none will question how much greater the lifesaving impact would have been for many more Afghans if the costs of just the flight time for this 12-hour mission had been invested in building capacity within the Afghan civilian health care system. Not until such investment can be made will dependency on U.S. and ISAF resources be reduced.

ISAF remains minimally involved in ANSF health sector reform, despite positive movement in late 2006. NATO member nations could have a major impact on ANSF capacity development by contributing 5- to 10-member medical or surgical teams to work along existing U.S. DOD teams in the 400-bed National Military Hospital in Kabul and the 4 other 100-bed regional hospitals. All hospitals are within secure ANA garrisons, so national caveats concerning hostile exposure need not apply.

Not as Hard as It Seems

Detailed examination of health sector reconstruction in Afghanistan demonstrates the interconnectedness of governance and capacity-building. Many well-intentioned infrastructure projects have been undertaken, including construction or renovation of hospitals, clinics, schools, and dormitories. Hundreds of millions of dollars have been spent on modern equipment and supplies to provide state-of-the-art medical and educational facilities. Highly publicized opening ceremonies are held where the facility or equipment is turned over, with much

fanfare, to the appropriate ministry. Often, however, a visit to the facility several months later reveals that it is not operating as intended, creating the perception that the government has failed. This is frequently due to the lack of skilled manpower and the difficulty of providing culturally sensitive training that is understood and adopted by local workers. A more appropriate alternative would include the purchase of basic medical equipment from India or Pakistan while simultaneously developing training programs that provide education in literacy and basic sciences, in addition to the technical skills required for the particular position. Didactic training is not as effective in Afghanistan as hands-on mentoring, so commitment to longer-term training engagement is essential.

After a female Afghan National Army Air Corps pilot bled to death during an emergency Caesarean section at a civilian women's hospital in Kabul, an obstetrics mobile training team did a comprehensive assessment of labor and delivery care. Findings included lack of rudimentary scientific knowledge and decisionmaking abilities concerning the use of basic medical equipment, such as blood pressure and heart rate monitors. A U.S. Army respiratory therapist brought advanced adult and neonatal ventilators, yet Afghan physicians preferred a 2-hour, hands-on workshop in using oxygen masks and hoods rather than learning to use the advanced ventilators. Basic decisionmaking needs included distinguishing between low-risk and high-risk patients, and managing life-threatening emergencies.

Despite these glaring limitations, most contributions to the health sector consist of expensive medical equipment that is quickly broken because of inconsistent power supplies, runs out of reagents and becomes useless, or is never set up at all. The biomedical equipment technician on the obstetrics mobile training team quickly became the most sought-after person in town, and he repaired patient monitors, sterilizers, infant incubators, surgical lights, suction machines, defibrillators, fetal heart rate monitors, infusion pumps, and laboratory equipment at multiple military and civilian hospitals around Kabul, while training Afghans twice his age to troubleshoot and repair such equipment after he left. Such mismatches between technology and maintenance capacity can be prevented by a proactive training effort in biomedical equipment repair. A collaborative training institute between the Kabul Medical University, the Ministry of Public Health, and the Ministry of Defense could train biomedical equipment technicians and many other allied health workers, such as radiology and ultrasound technicians and respiratory therapists. Graduates from this institute could work in government, military, or private hospitals and could be the foundation for economic development in the private sector.

Infrastructure development in conflict-prone settings often must include forgoing some efficiency in order to promote indigenous job creation and employment of host-nation contractors. For example, more local workers will need to be hired and trained for particular tasks in the initial years, leading some to question effectiveness of training programs. In fact, this practice broadens the opportunities for economic development to more Afghans and builds broad-based community support for the project. Development of host-nation capacity to drive the strategic and planning processes takes much time and patience but is essential in the

long run.¹⁵ Afghans are best able to recommend what will and will not work and must be involved in every aspect of planning and implementing such development.

Achieving Success

The health sector has significant manpower, training, economic, referral, and geographic distribution factors that require a holistic systems approach. Afghanistan lacked a strong health care delivery system before the Soviet invasion, and subsequent fighting devastated what did exist. Women are highly represented in the health sector in much of the world; their cultural exclusion from much of Afghan society makes effective reconstruction more difficult. The long history of ethnic and tribal conflict between Pashtuns, Tajiks, Uzbeks, and Hazaras,

with recent decades being marked by changing associations of militias, warlords, and mujahideen, complicates any effort that requires working cooperatively. Even with the Taliban extremists largely removed, working with others is anathema; consolidation of control is the standard.

Sustainable development of the health sector requires work against these ingrained cultural tendencies, but it must be done on Afghan terms and timelines, not those from the West. Engagement provides many opportunities to improve governance, reduce corruption, and validate the government's ability to provide for the people. All projects must be done in concert with Afghan priorities, which require building enduring personal and professional relationships, making every attempt to understand cultural issues, and adjusting timelines accordingly. As reconstruction of the ANA medical system was under way, a senior Afghan official said, "Don't look at us in a U.S. DOD-sized mirror. We're very young compared to you." The Afghan leadership recognizes that it is very new at developing a national army and national pride, and while they desire to move forward, it will take time, commitment, and much hard work. Another official said, "It took you over two hundred years to get where you are. Don't expect us to change overnight."

Every aspect of every project must emphasize collaboration. Ministries must work together at the central level; internal components within each ministry must work efficiently; and each central ministry must work well with its regional and provincial components. Entry-level positions must be created wherever possible, especially for women, and basic education and literacy training must be incorporated. Projects must include work at the provincial and district levels, so jobs can be created at these levels rather than only in the capital, Kabul. Health-related education and economic opportunities offer acceptable alternatives to poppy cultivation and armed resistance. Facilitating sustainable development of capacity in good, effective governance is the center of gravity for all stability operations in Afghanistan.

A recent burn-prevention education initiative funded by a private donor emphasizes these key governance issues. The initiative develops capacity in the Ministries of Public Health, Women's Affairs, and Education, both centrally and at the provincial levels. The Ministry of Public Health lacks capacity to manage private sector funding, so the project is managed by SOZO International, an NGO that specializes in

community development. Early phases of the 4-year project developed training programs in schools, hospitals, and community social centers in Kabul, Jalalabad, and Herat. This program is particularly important because it strengthens the central government's ties to provincial and rural areas. It has no infrastructure costs and minimal supply costs. If funding were available, the program could be expanded across the entire country and could develop needed burn treatment capacity. Current U.S. Government funding is unavailable for such valuable projects.

Measuring Success

Each area of development—curative care, public health, health education and training, and disaster preparedness and response—must be broken down into its component parts: infrastructure, equipment, supplies, manpower, training, policy and strategy, and objective proficiency—and measures of effectiveness must be developed for each component. A plan for sustainability of each component must then be developed that considers the current and near-future state of the economy and society in Afghanistan. CSTC—A developed such a planning process within the ANA that considered initial army health sector reconstruction efforts; this tool served as both a planning tool for DOD and a mentoring tool for ANA leaders.

Tactical development of the ANSF health care system included a biweekly focus on staffing, training, and infrastructure, including development of army medics, police medics, medical logistics, evacuation capacity, preventive medicine, and planning for operations. Strategic development added strategy and policy development, medical facilities, clinical operations, health care administration, and civilian access. Measures of effectiveness were basic, limited to percentages of required staff that were in place and trained, buildings constructed or renovated, and equipment purchased. More meaningful metrics would include access to care, quality of care, availability of necessary supplies, diagnostic and laboratory tests, and medications, and efficiency of care delivered, but these are far in the future. Both the progress toward existing milestones and the reconstruction and development processes themselves were carefully evaluated every 2 weeks, leading to both minor and major changes in tasks and priorities. This assessment process was adopted by other CSTC—A sections working with the ANA. Such processes are a foundation that should be adopted for use with integrated civilian sector reconstruction, in health, and in other sectors of the economy.

An inexpensive effort with great dividends in multi-ministry capacity building was the first-ever Emergency Planning Workshop held in Kabul in December 2006. The Ministry of Public Health and ISAF co-sponsored the workshop, which was held in the ANA hospital auditorium. Participants included the ANA, ANP, the private Kabul Ambulance Association, the International Red Crescent Society, an Afghan senator, and several NGO hospitals. ISAF brought a Royal Air Force technical expert from Great Britain as the keynote speaker. The most valuable aspect of the conference was capacity building within the Ministries of Public Health and Defense during the 6-week planning effort leading

up to the workshop. A subsequent workshop held in January 2008 built on the earlier momentum.

Recommendations

The solution to successful stability operations in Afghanistan rests in unity of command and access to resources sufficient to make a difference. An operational-level health sector reconstruction office is needed in Kabul. It should be staffed primarily by personnel from DOD and USAID, with additional technical experts from DHHS, the U.S. Department of Agriculture (USDA), ISAF, academia, and NGOs. This office should develop health sector projects, set priorities, and integrate and unify nationwide planning and implementation with the government of Afghanistan, representatives of other nations, and international organizations and NGOs. This office must have coordinating authority with all health sector activities in the country, including U.S. DOD efforts with the ANA and ANP, and with ISAF.

The tactical foundation to build on is the PRT. More teams are needed with more expertise, more integration of efforts within each team, much more access to and flexibility with resources, and more centralized control, coordination, and direction for health sector work. PRTs must operate against broad but clearly defined goals and objectives and not freelance. Any MEDCAPS or village medical outreach activities should be coordinated by these teams.

A reachback support office is needed to provide additional technical expertise and administrative, planning, financial, and contract support, and to manage interagency coordination in Washington, DC. It should include strong links to DOD, USAID, DHHS, USDA, and State, with full-time

personnel assigned from each of these agencies. Development of emergency medical and disaster management systems, maternal and child care, and public health systems requires access to specialized expertise that often exists only outside government, so resources must support crucial academic and

private sector partnerships. As a first step toward this function, a technical and planning reachback support office was created early in 2007 at the Center for Disaster and Humanitarian Assistance Medicine at the Uniformed Services University of the Health Sciences, the DOD medical school in Bethesda, Maryland. This office has created a comprehensive health sector improvement and integration plan for the ANSF,¹⁶ and its staff are demonstrating their usefulness in other DOD stability operations by providing technical expertise and support to efforts outside of Afghanistan.

The overall responsibility for these stability operations must be vested in one government department or agency. That organization must be able to plan and implement projects, have sufficient technical expertise, and be integrated into military operations and able to operate in an unstable and insecure environment. It must have a reliable resource stream that is available for capacity-building, administrative and programmatic support, and timely access to academic, private sector, and NGO expertise. Funding must be sufficiently flexible to remove the current barriers between Afghan civilian and security sector work.

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Stabilization and reconstruction plans must evolve with the dynamic conditions on the ground.

Given the current security challenges in Afghanistan, Congress should initially assign the overall responsibility and funding for these efforts to DOD, which already has the responsibility and resources for developing an effective ANSF; new authorities must allow Afghan Security Forces funds to be used in the civilian sector where necessary to build a sustainable ANSF system. Additional civilian reconstruction funds must be provided to fully develop the civilian sector in conjunction with existing efforts by USAID and other donors. Sources should include humanitarian assistance and counternarcotics funds so that preventive programs and alternative livelihoods can be fully developed. As development progresses and Afghanistan is stabilized, the lead government agency for health sector reconstruction should be reevaluated to determine if DOD should retain this responsibility for the long term.

Funding should be restricted to develop one integrated ANSF health care delivery system, not separate systems for the ANA and ANP. Supporting capacity must be developed in the civilian sector for medical education and training, disaster preparation and emergency response, and family member care, rather than creating an elite system for security forces and the privileged classes.

The initial focus should be on health sector reconstruction that directly supports counterinsurgency efforts, such as medical infrastructure and training institutes that offer entry-level education (literacy, basic scientific and vocational skills) and economic opportunities at the provincial and district levels. These training and economic opportunities must specifically empower women, both to reverse the regressive effects of the Taliban's exclusion of women from society, and to return health sector staffing to its pre-Taliban gender balance, where women were active participants. More economic opportunity for women builds individual and community resilience by permitting rural families to survive without needing to please the Taliban insurgents. Specific local requirements should be generated by tactical-level PRTs, perhaps using MEDCAP-like activities; implementation of all local activities should be managed by these PRTs, with adjustments and modifications according to local conditions. As a governance and anticorruption tool, projects should begin in provinces and districts where local government authorities demonstrate their commitment by providing security and reducing poppy cultivation. Unskilled workers who are currently engaged in poppy cultivation can be offered jobs in building construction, a culturally acceptable alternative livelihood. This type of reconstruction will begin to address the pervasive poverty that debilitates the government and facilitates the recruitment of unemployed youths into militias, drug-related activities, and the insurgency.¹⁷ Projects along the Pakistan border will facilitate essential political reform and economic development at the local level.

Follow-on health sector efforts should focus on rapidly strengthening the institutions required for long-term stability, including health care for uniformed ANP in rural areas and on the borders, development of combat casualty care and evacuation for ANA and ANP in an integrated emergency medical and trauma management system in the civilian sector, and health care for army and police family members in an upgraded civilian health sector. This will improve recruitment and retention of quality personnel into the ANA and ANP and develop professional security institutions. All aspects of health education and training, and the supporting institutions of logistics, communication, and transportation,

must be developed to enable the maturation of the ANSF, benefit civilian sector growth, and provide additional economic opportunities.

Multisector components include better integration of counter-narcotics efforts, taking on preventive education by social marketing, rehabilitation of users, and more comprehensive consideration of alternatives to poppy cultivation. Development of the private sector is possible in health-related areas, such as biomedical equipment repair and maintenance and fee-for-service health care. These and other opportunities will grow when a small degree of stability and security allows private sector investment to take root. Action now to provide a foundation of essential health care services will be the catalyst for these and other reconstruction efforts.

Conclusion

In unstable, conflict-sensitive environments, the condition of infrastructure is often a barometer of whether a society will slip further into violence or make a peaceful transition out of the conflict cycle. Infrastructure adds "arms and legs" to strategies aimed at winning "hearts and minds."¹⁸ But DOD should not take on infrastructure development alone because it lacks the long-term commitment, long-term developmental mindset, in-depth cultural awareness, economic expertise, and relationships with international organizations necessary for long-term strategic partnerships and transition as security and stability are achieved. The foundational organizational elements for stability operations in Afghanistan are in place, but major adjustments must be made rapidly to integrate civilian and military components into effective counterinsurgency tools so that long-term advances in reconstruction and economic growth may begin. Resource requirements are but a fraction of that being spent to maintain military forces today. Our enemies in the region have waged a war that has compelled us to rethink our assumptions. We must now reconfigure our forces and the tools with which they work, reinvigorate our alliances within government and without, and recommit ourselves to effective action.¹⁹

Notes

¹ Greg Behrman, *The Most Noble Adventure* (New York: Free Press, 2007), 20.

² Seth Jones et al., *Securing Health: Lessons from Nation-Building Missions* (Santa Monica, CA: RAND Corporation, 2006), 281–289.

³ Field Manual 3–24, *Counterinsurgency* (Washington, DC: Headquarters Department of the Army, December 2006), 1–19.

⁴ DOD Directive 3000.05, "Military Support for Stability, Security, Transition, and Reconstruction Operations," November 28, 2005, defines *stability operations* as "military and civilian activities conducted across the spectrum from peace to conflict to establish or maintain order in States and regions."

⁵ Michael McNerney, "Stabilization and Reconstruction in Afghanistan: Are PRTs a Model or a Muddle?" *Parameters* (Winter 2005/2006), 32–33.

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Center for Technology and National Security Policy

Hans Binnendijk
Director

⁶ John Boone, "Afghan Revival Work Failing, Says Oxfam," *Financial Times*, November 20, 2007.

⁷ Hans Binnendijk, "Finishing the Job in Afghanistan," *The Wall Street Journal*, November 10, 2007, A11.

⁸ Merriam Mashatt, Daniel Long, and James Crum, *Conflict-sensitive Approach to Infrastructure Development*, Special Report 197 (Washington, DC: United States Institute of Peace, January 2008), 11, available at <www.usip.org/pubs/specialreports/sr197.pdf>.

⁹ John Nagl, *Counterinsurgency Lessons from Malaya and Vietnam: Learning to Eat Soup with a Knife* (Chicago: University of Chicago Press, 2002), 25–28.

¹⁰ DOD Directive 3000.05.

¹¹ Robert Wilensky, *Military Medicine to Win Hearts and Minds* (Lubbock: Texas Tech University Press, 2004), 104–107. Wilensky discusses the Vietnam experience with MEDCAPs, pointing out that while providing positive press back home, the actual MEDCAP effort in Vietnam undermined long-term U.S. goals.

¹² Alison Young, "Big Success or Sad Story," *Atlanta Journal-Constitution*, November 18, 2007, A1.

¹³ Eugene Bonventre, "Monitoring and Evaluation of Department of Defense Humanitarian Assistance Programs," *Military Review* (forthcoming).

¹⁴ Martin Bricknell and Donald F. Thompson, "Roles for International Military Medical Services in Stability Operations (Security Sector Reform)," *Journal of the Royal Army Medical Corps* 153, no. 2 (September 2007), 95–98.

¹⁵ Mashatt, 3.

¹⁶ Program Management Plan, "Planning Document for Healthcare System Improvement and Integration for the Afghan National Security Forces," Center for Disaster and Humanitarian Assistance Medicine, December 26, 2007.

¹⁷ Barnett Rubin, "Saving Afghanistan," *Foreign Affairs* 86, no. 1 (January–February 2007), 66.

¹⁸ Mashatt, 12.

¹⁹ Robert Cassidy, *Counterinsurgency and the Global War on Terror* (Westport, CT: Praeger Security International, 2006), 152.

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